CODING BASICS:

Navy Breakout Session
TRICARE Data Quality Training Course
9 June 2005

What is Coding?

- Coding is classifying data and assigning a representation for that data
- Codes are used from either a nomenclature or classification system
- A nomenclature is a systematic listing of proper names
- A classification is the grouping together of similar items
- Medical coding is classifying data and assigning a representation for that data

Purposes of Coding

- Permits retrieval of information for users
  - Research
  - Quality studies
  - Administrative decisions
- Key to Population Health
  - Provides ability to identify trends
- Accurate workload representations
  - Relative Value Unit (RVU) determination of workload
- Reimbursement
  - **Validates necessity of services based on diagnos**
  - **Diagnosis and procedures must be linked**

What is ICD-9 Coding?

- Clinical terms into numbers
- Origin of classification
  - Mortality information adopted 1898
  - Morbidity information adopted 1959
- World Health Organization (WHO)
  - 9th revision of ICD published 1978 for
  - International use
- United States Public Health Services
  - Modified ICD-9 to meet the needs of American hospitals and called it *International Classification of Diseases,* Ninth Revision, Clinical Modification

ICD-9-CM

- ICD-9-CM Coordination and Maintenance Committee
  - Meetings twice per year
  - Chaired by both NCHS and CMS
  - Diagnoses (volumes 1 & 2) – NCHS
  - Procedures (volume 3) – CMS
- Annual updates every 1 October to keep classification current with:
  - Current and new understanding of diseases
  - New procedures/technologies
  - Assist with better data collection and use

Characteristics of ICD-9-CM

fficial ICD-9-CM guidelines

olume 1 Diseases: Tabular List of Diseases and Injuries

- Classification of diseases and injuries Codes 000-999
- Supplementary classifications
  - V Codes
  - E Codes

olume 2 Diseases: Alphabetic Index to the disease entries

olume 3 Procedures: Tabular List and Alphabetic Index; a classification system for surgical, diagnostic, and therapeu procedures (alphabetic index and tabular list).

fficial Reference: The American Hospital Association's *Coding Clinic for ICD-9-CM*

ICD-10-CM

- World Health Organization (WHO)
  - Tenth edition of ICD was issued in 1993
  - WHO is responsible for maintaining it
  - ICD-10 is already widely used in Europe
  - Each world government is responsible for adapting ICD-10 for their use

- ICD-10-CM will replace ICD-9-CM, Volumes 1 and 2
  - Expansion of injury codes
  - Creation of combination diagnosis/symptom codes
  - Addition of a sixth character
  - Updating and greater specificity of diabetes mellitus codes
  - Incorporation of common fourth and fifth digit subclassifications

- Diagnosis Related Groups (DRG) are based upon ICD-9-CM

- There is not yet an anticipated implementation date for the ICD-10-CM. There will be a two year implementation window once the final notice to implement has been published in the Federal Register.

ICD-9-CM to ICD-10-CM Conversion Diseases of the Blood and Blood-forming Organs

ICD-9-CM Code	ICD-9-CM Abbreviated Title	ICD-10-CM Code	ICD-10-CM Abbreviated Title
281.0	PERNICIOUS ANEMIA	C51.0	PERNICIOUS ANEMIA
281.1	VIT B 12 DEFIC ANEMIA NEC	D51.1	HEREDIT MEGALOBLAST ANEM
281.1	VIT B 12 DEFIC ANEMIA NEC	D51.2	TRANSCOBALAM IN DEF ANEM
281.1	VIT B 12 DEFIC ANEMIA NEC	D51.3	DIETARY B12 DEF ANEM NEC
281.1	VIT B 12 DEFIC ANEMIA NEC	D51.8	B12 DEFICIENC ANEM NEC
281.1	VIT B 12 DEFIC ANEMIA NEC	D51.9	B12 DEFICIENC ANEM NOS

Types of Procedure Codes

- ICD-9-CM, volume 3 to be used for hospital inpatient coding

- CPT-4 and HCPCS to be used by physicians and other health care services, including hospital outpatient services

ICD-10 Procedure Coding System (PCS)

- CMS contracted 3M Health Information Systems to develop ICD-10-PCS to replace ICD-9-CM, Volume 3
- Each code must include seven characters, If a character is not applicable to a specific procedure, the letter Z is used
- Objectives:
  - Completeness
  - Expandability
  - Multiaxial
  - Standardized terminology

ICD-10-PCS Medical and Surgical Procedures

1	2	3	4	5	6	7
Section	**Body System**	**Root operation**	**Body part**	**Approach**	**Device**	**Qualifier**

ICD-10-PCS Tabular

Section

Body System

Root Operation

1: OBSTETRICS
0: PREGNANCY

Y: DELIVERY: Assisting the passage of the products of conception from the genital canal

Body Part Character 4	Approach Character 5	Device Character 6	Qualifier Character 7
0 Products of Conception	Z None	Z None	3 Low Forceps 4 Mid Forceps 5 High Forceps 6 Vacuum 7 Version Z None
1 Products of Conception, Retained	B Transorifice Intraluminal	Z None	Z None

Background History of Healthcare Common Procedure Coding System (HCPCS)

Omnibus Budget Reconciliation Act of 1986 (OBRA) required
PT/HCPCS coding for outpatient services for federally
nded patients
CMS (formerly called HCFA) developed a three-part system
standardize the coding system used to process Medicare cl
Developed HCPCS to support the need to bill for all services
ot just those in CPT)
Used for all services: surgical, medical, supplies, materials
d injections

Components of HCPCS

- Level I: CPT Codes
  - 80% of HCPCS can be coded using CPT
- Level II: HCPCS (AKA National Codes)
  - Developed by CMS to identify other servic
- Level III: Local Codes
  - Codes developed by local Medicare carrie
  - Discontinued in 2003

Level I: Current Procedure Terminology (CPT)

Published, copyrighted by AMA since 1966
Developed as a method of communication between M.D.s and third-party payers
Intended to be used for reimbursement (*unlike* ICD-9-Nomenclature
Updated annually on January 1
Official Reference: *CPT Assistant*

Level II: HCPCS Codes

- One alphabetic character followed by four digits (A0000 – V9999)
- CMS (formerly HCFA) developed the Healthcare Procedural Coding System in 1983.
- Because CPT lacks many codes for nonphysician procedures and services, CMS created codes to supplement CPT and to describe supplies and drugs.
- Required by Medicare but…

  - Used by most insurance companies that understand the value of accurate codes

Level II: HCPCS Codes

- Allows for continuity and specificity when billing.
- Uniformity helps the effort to collect uniform health service data.
- Codes are approved and maintained jointly by the Alpha-Numeric Workgroup, consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association.
- Codes and descriptions are updated every January by CMS.

Level II: HCPCS Codes

- Supplies: wheelchairs, hearing aid batteries and crutches, e.g., **V5060** Hearing aid, monaural, behind the ear

- Injection codes: identify actual substances, e.g., **C9105** Injection, hepatitis B immune globulin, per 1ml

When are HCPCS Codes Used??

Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Procedural Coding 1.3 states:

- **Level I** HCPCS are commonly referred to as Current Procedural Terminology (CPT). They form the major portion of the HCPCS coding system, covering most services and procedures. CPT codes supersede Level II codes when the verbiage is identical.

- **Level II** codes supersede Level I codes for similar encounters, when the verbiage of the Level II code is more specific. HCPCS include evaluation and management services, other procedures, supplies, materials, injectables and dental codes. Having a code number listed in a specific section of HCPCS does not usually restrict its use to specific profession or specialty.

Level III: Local Codes

- The Health Insurance Portability and Accountability Act (HIPAA) required there be standardized procedure coding.
- All unapproved HCPCS Level III codes/modifiers were eliminated in December 2003 to meet this requirement.
- Level II codes have increased 47% because of the loss of local reporting.

Medical Record Documentation

Complete Documentation

Correct Medical Coding

Appropriate Reimbursement

e critical factor in determining the level of ca

Not what you did….but what you documented!

How do coders code?

Coders need and expect a SOAP format note
Coders divide a note into 3 sections
- Subjective
- Objective
- Assessment and Plan

The ranking of the sections give the Evaluation and management (E/M) code (i.e. level of effort for this case
- Based on Centers of Medicare Services (CMS) rules
- Main driver of RVU

New patient visit – ALL 3 components are required
Established patient visit – must meet 2 of 3 key component

Common Coding Errors

ICD-9 Coding Errors: Sequencing
Principal Diagnosis
Specificity
Missed Diagnoses

E/M Coding Errors: Level of Service
Preventative vs. New/Established

Sequencing - List first the code for diagnosis, condition, problem, or other reason for encounter to be chiefly responsible for the services provided.

CC: Annual Physical

Subjective: 48yo male here for physical has chronic elbow p
(tennis elbow). Takes Vioxx PRN, needs refill.

Assessment: Healthy adult male with Lateral epicondylitis

Provider ICD-9 Coding: 726.32 Lateral epicondylitis
V70.0 Physical

Correct Sequencing: V70.0 Physical
726.32 Lateral epicondylitis

Principal Diagnosis - Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been confirmed by the physician.

CC: Persistant cough

Subjective: 59yo female to clinic for F/U evaluation of chronic cough since beginning of April. Tx'd w/Humibid, Zithromax, Allegra w/o relief. Cough worse when lying down.

Objective: Vitals done.
ENT: TM's clear; throat clear, (0) cervical adenopathy

Assessment: SAR vs URI

Provider ICD-9 Coding: 465.9 URI
Correct Coding: 786.2 Cough

Specificity – Coding to the highest degree of accuracy as possible.

CC: F/U visit; pt seen @ SMH ER, check for meningitis (-).

Subjective: W/U @ SMH 2 nights ago for meningitis (CT, LP & other labs.) Here for F/U. Feeling better today but still c/o body aches. < fever.

Objective: Vitals
TM's clear
Tonsills erythematous w/exudate
RST (+)

Impression: GABHS Pharyngitis

Provider ICD-9 Coding: 462 Acute Pharyngitis
Correct ICD-9 Coding: 034.0 Strep Pharyngitis

Specificity – Coding to the highest degree of accuracy as possible.

C: Arm pain S/P fall

bjective: 12yo boy presents with arm pain, after falling from skateboard

bjective: Vitals
X-ray (+) closed fracture, neck of radius
No other injuries

sessment: Fracture of radius

ovider ICD-9 Coding: 813.00 Fracture, upper end of forearm, unsp
rrect ICD-9 Coding: 813.06 Fracture, neck of radius
E885.2 Fall from skateboard

Missed Diagnoses:

C: Seasonal allergies
ubjective: 8yo presents with allergies, rhinnorrhea, sneezing, cough

ssessment:
1. Asthma – mod persistent
2. Allergies
3. Tonsilar hypertrophy, possible OSAS

an:
1. Allegra 180mg qHS
2. Peak Flow Education
3. Consider ENT consult for tonsils, OSAS

rovider ICD-9 Coding: 477.9 SAR
orrect ICD-9 Coding: 477.9 SAR
493.00 3 Extrinsic Asthma, mod persistent
474.11 Hypertrophy tonsils

Level of Service:

CC: Health check for BP and Cholesterol

Subjective: Needs refill of Viagra – working great

Objective: Exam deferred; vitals taken; chol labs listed

Assessment: BP controlled; chol controlled

Provider ICD-9 Coding: 272.4 Unspecified Hyperlidemia, V68.1 Refill
Correct ICD-9 Coding: 272.4, 401.9, 607.84, V68.1

E/M Provider Coding: 99213 Expanded Problem Focused
0.67 RVUs
Correct Coding: 99212 Problem Focused, 0.45

Preventative vs. New/Established

2 month old presents for Well Baby Exam

ICD-9 Code: V20.2 Well Baby Exam

E/M Provider Coding: 99213 Established patient
0.67 RVUs

Correct Coding: 99391 Preventative Med visit, Infant
1.02 RVUs

RVUs for Office Visit E&M Codes

99201	OFC/OUTPT E&M NEW MINOR 10 MIN	0.45	CMS
99202	OFC/OUTPT E&M NEW LOW-MOD 20 MIN	0.88	CMS
99203	OFC/OUTPT E&M NEW MOD-SEVER 30 MIN	1.34	CMS
99204	OFC/OUTPT E&M NEW MOD-HI 45 MIN	2.00	CMS
99205	OFC/OUTPT E&M NEW MOD-HI 60 MIN	2.67	CMS
99211	OFC/OUTPT E&M ESTAB 5 MIN	0.17	CMS
99212	OFC/OUTPT E&M ESTAB MINOR 10 MIN	0.45	CMS
99213	OFC/OUTPT E&M ESTAB LOW-MOD 15 MIN	0.67	CMS
99214	OFC/OUTPT E&M ESTAB MOD-HI 25 MIN	1.10	CMS
99215	OFC/OUTPT E&M ESTAB MOD-HI 40 MIN	1.77	CMS

RVUs for Preventive Medicine Visit E&M Codes

99381	INIT PREV MED E&M NEW PT; INFANT	1.19	CMS
99382	INIT PREV MED E&M NEW PT; 1-4 YRS	1.36	CMS
99383	INIT PREV MED E&M NEW PT; 5-11 YRS	1.36	CMS
99384	INIT PREV MED E&M NEW PT; 12-17 YRS	1.53	CMS
99385	INIT PREV MED E&M NEW PT; 18-39 YRS	1.53	CMS
99386	INIT PREV MED E&M NEW PT; 40-64 YRS	1.88	CMS
99391	PRD PREV MED E&M EST PT; INFNT <1YR	1.02	CMS
99392	PRD PREV MED E&M EST PT; 1-4 YRS	1.19	CMS
99393	PRD PREV MED E&M EST PT; 5-11 YRS	1.19	CMS
99394	PRD PREV MED E&M EST PT; 12-17 YRS	1.36	CMS
99395	PRD PREV MED E&M EST PT; 18-39 YRS	1.36	CMS
99396	PRD PREV MED E&M EST PT; 40-64 YRS	1.53	CMS

RVUs for Antepartum Codes

0500F	INITIAL PRENATAL CARE VISIT2	0.83	MHS
0501F	PRENAT FLW SHEET MED REC 1ST VISIT1	0.83	MHS
0502F	SUBSEQUENT PRENATAL VISIT	0.83	MHS

REMEMBER:

- The key to coding compliance is
  - Correct documentation
  - Correct codes
  - Correct guidelines

Coding Credentials

- AHIMA – American Health Information Management Association

  RHIA : Registered Health Information Administrator
  RHIT: Registered Health Information Technician
  CCS: Certified Coding Specialist
  CCS-P: Certified Coding Specialist – Physician - based
  CCA: Certified Coding Associate

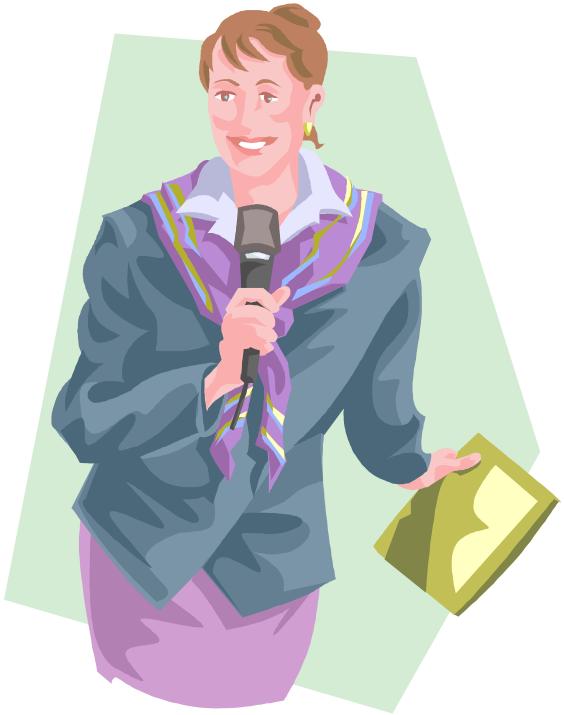
- AAPC – American Academy of Professional Coders

  CPC: Certified Professional Coder
  CPC- H: Certified Professional Coder - Hospital

Coding Links

oding Guidelines: Professional Services and Outpatie
ing Guidelines, Unified Biostatistical Utility (UBU):
ttp://www.tricare.osd.mil/org/pae/ubu/default.htm
e Uniform Business Office (UBO) Business Rules:
www.tricare.osd.mil/ebc/rm_home/ubo_documents_policy_guidance.cfm
CM:
ters for Medicare and Medicaid (CMS):
ttp://www.cms.hhs.gov
onal Center for Health Statistics (NCHS):
ttp://www.cdc.gov/nchs/icd9.htm
American Medical Association: http://www.ama-assn.org
can Hospital Association (AHA): http://www.aha.org/aha/inde

QUESTIONS?



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